RONALD FANTOZZI

6 OF 18

ADMIT

FANTOZZI, Ronald Flanagan SMRMC 10/05/1998
MR#: 221342 ACCT#: 8278533 DOB: [redacted]/1962 IN: 0816 EXAM: 0835

PROBLEM: Abdominal pain.

HPI: The patient is a 36-year-old [redacted] who has a past history of both Crohn's disease requiring partial resection of his bowel and he also has a history of right-sided kidney stones with a ureteral stent present. He was seen in the emergency department last night with right lower quadrant pain and was advised at that time that this was due to Crohn's disease. He was treated with Demerol and Phenergan and advised to recheck with his doctor if he were not improving on his own. Today, he returned by ambulance because of worsening symptoms with continued unrelenting pain in spite of the medication and vomiting.

PMH: Also significant for hepatitis C.

ALLERGY: No known allergies.
MEDS: Luvox.
IMM: Last tetanus is unknown.
PMD: Dr. Boulanger. He has also been seeing Dr. Monzel for his Crohn's disease. The expectation of Dr. Boulanger in the patient was that he would see Dr. Monzel when he came to the emergency department, but he was unavailable; therefore, I saw the patient instead.

EXAM: Vital Signs: Temperature 37.3, pulse 80, respiratory rate 18, blood pressure 118/80. General appearance: The patient was lying on his side and appeared pale and uncomfortable.

ABDOMEN: He had high pitched, tingling bowel sounds present. He had generalized tenderness in his abdomen and worse in the right lower quadrant.
CHEST: He had clear lung fields and normal heart sounds.

COURSE/PROCEDURES: He was given IV fluids, Demerol and Phenergan with no relief of his symptoms.

X-RAY: Read by the radiologist.
Question partial small bowel obstruction.

LAB: White blood count was 11,300, which was the same range that it was last night. Another urinalysis was obtained and was unremarkable. Electrolytes were obtained at 1200 hours, but are not available at the time of this dictation.

DX:
1. Abdominal pain with probable impending small bowel obstruction secondary to his Crohn's disease.

ADMIT

FANTOZZI, Ronald Flanagan SMRNC 10/05/1998
MR#: 221342 ACCT#: 8278533 DOB: [redacted]/1962 IN: 0816 EXAM: 0835

MDM/TX/COUNSEL/COORD:

1. Dr. Monzel and Dr. Boulanger were contacted. The patient will be admitted for further observation and treatment of his symptoms.

Terrence W. Flanagan, MD

DOD:10/05/1998 TF /tam
DOT:10/05/1998
cc: Dr. Boulanger
Dr. Monzel

Dictate, Inc. 207-539-8477 for NES-St. Mary's Regional Medical Center
VF#: 0168

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ST. MARY'S REGIONAL MEDICAL CENTER
LEWISTON, MAINE

NURSING CONTINUATION SHEET

CONTINUED

NO. [illegible] PAGE 7 OF

FIRST

Fantozzi Ronald Flanagan 10-5-98

0830	112/80	80	18	#20 angio Lt hand D5 .9NS hung	
0840				Demerol 50mg IV	
0845				Phenergan 25mg IV	Voided
0850				Labs drawn	
0915		84			To XRay
					Return from XRay
1045	126/70	84			States no relief of pain from pain meds.
1105				Demerol 75mg IV	Voided lg amt - U/A to lab
1130					Report to MS - Abd sift BS active

RN/LPN DD [signature]

RN/LPN

DOCTOR'S SIGNATURE

MEDICAL RECORDS COPY

500685.011.0123

St. Mary's Regional Medical Center

Emergency Department Radiology Request

Examination(s) Requested: Abd. Series

Reason for Examination: R sided abd pain

Examinations Ordered By: Flanagan

MR 221342

ADM 10/05/98

FANTOZZI, RONALD M M

40 POLAND RD

AUBURN ME 04210

218103-01 999999

[redacted]/62 7823673

Preliminary Reading

E.D. Interpretation

☐ Normal ☐ No Acute Abnormality

☐ Other (specify)

Emergency Physician's Signature: _____

Radiology Interpretation

☐ No E.D. interpretation

☐ Agree with E.D. ☞ no further action

☐ Disagree with E.D.

Radiologists recommendation:

? dang partial SBO

E.D. called: Date

Time

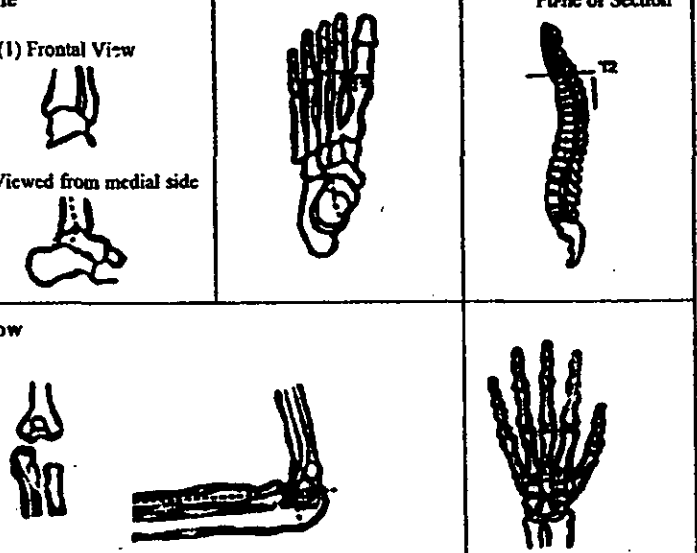
Follow-Up Note

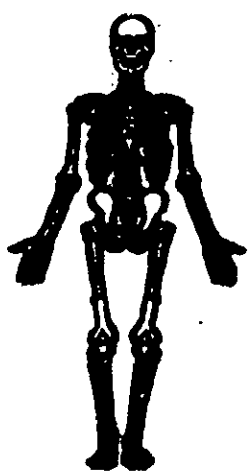
(Must be completed in cases of recommendation.)

Date of Follow-Up: _____

☐ E.D. Chart reviewed/No follow-up necessary

E.D. Physician's Signature: _____





White - Medical Record • Yellow - E.D. File Copy • Pink - Radiology

ST. MARY'S REGIONAL MEDICAL CENTER

Lewiston, ME 04240

8278533 MS-301 22-13-42

FANTOZZI, RONALD M
DOB: [redacted]/62
MICHAEL MONZEL, M.D.
Admitted: 10/05/98

HISTORY/PHYSICAL

Dictator: MICHAEL MONZEL, M.D.

CHIEF COMPLAINT:

This 36-year-old male with Crohn's disease admitted with progressive severe right upper quadrant pain and repetitive vomiting. The patient has a history of Crohn's dating back to around 10 years. He underwent ileal right colonic resection about 7 years ago. He was quite quiescent after that until the last several months when he has had progressive pain and intermittent diarrhea. A recent work up has revealed a narrowing of the distal neoterminal ilium and a narrowing, although not severe, at the anastomosis by colonoscopic examination with ulcer at the anastomosis. The patient had been place on Pentasa. There has been mild improvement although diarrhea recently has increased after gastrointestinal series. A CT scan has also been performed which revealed no other pathology.

The patient had been admitted in mid September for a presumed left ureteral calculus. He has not had any gastrointestinal symptoms but over the weekend he had pain and distention, has progressive diarrhea and x-ray has suggested a partial bowel obstruction.

Other medical problems include a history of hepatitis C positivity with evaluation of this problem including liver biopsy in January of 1998 which shows mild hepatitis being present. The hepatitis C R&A volumes were actually high but it was elected not to treat him for fear of aggravation of his inflammatory bowel disease.

The patient also is now placed on steroids and was presumed to have a flare of his Crohn's because of the history of hepatitis C.

Other problems include a history of renal calculi. He has a history of previous ileal colonic resection.

MEDICATIONS: Include Pentasa and Darvocet.

ALLERGIES: None known.

SOCIAL HISTORY: Employed at Falcoln shoe. He is married. He lives locally. He has about one to two beers two to three times per week. Tobacco use, none currently.

FAMILY HISTORY: Noncontributory.

REVIEW OF SYSTEMS: As per history and present illness.

(SEE NEXT SHEET)

PHYSICAL EXAMINATION: Reveals an uncomfortable male who is in no acute distress. The temperature is 37 C, pulse 84, blood pressure 130/80, respiratory at 16. **SKIN:** Without rash. **HEENT:** Negative. **LUNGS:** Clear. **HEART:** No murmur. **ABDOMEN:** Some fullness, right sided tenderness, no rebound, no mass. **RECTAL:** No mass. Hemocult negative. **EXTREMITIES:** Benign.

LABORATORY DATA: X-rays reviewed. White count is 11,300 with 68% granulocytes, 21% lymphocytes, hematocrit 37, sodium is 139, potassium 3.6, chloride 104, CO2 28. Liver function tests were normal and amylase was 50. KUB shows distal small bowel that is consistent with partial small bowel obstruction.

IMPRESSION:

1. Crohn's disease with recent documentation of flare now presenting with partial small bowel obstruction. The evaluation of the anastomosis at colonoscopy suggests that there clearly should be room to work with medication management as the stricture was not all that tight. Will proceed with recommending IV steroids, bowel rest and will follow labs including liver function tests. Analgesic to be provided. NG tube to be held for the present time.
2. Renal calculus. Will check urinalysis.

MICHAEL MONZEL, M.D.

D: 10/05/98 MM
T: 10/06/98 wak

cc: MICHAEL MONZEL, M.D. (P)
D3/ON (P)

ST. MARY'S REGIONAL MEDICAL CENTER

Lewiston, ME 04240

8278533 MS-301 22-13-42

FANTOZZI, RONALD M
DOB: [redacted]62
MICHAEL MONZEL, M.D.

REPORT OF CONSULTATION

Admitted: 10/05/98

CONSULTING PHYSICIAN: MICHAEL BOULANGER, M.D.
Date of Consult: 10/06/98

CHIEF COMPLAINT: Severe, incapacitating subjective perception of abdominal pain.

HISTORY OF PRESENT ILLNESS: Ronald Fantozzi is a 36-year-old white male with a complicated medical and surgical history admitted by Dr. Monzel yesterday in light of a severe and incapacitating abdominal pain presumed secondary to Crohn's flare with question of early partial small bowel obstruction. The patient has been followed in my practice for internal medicine care over the last several years. He was just hospitalized in August for possible nephrolithiasis and renal colic. The patient has a long standing history of adjustment disorder, anxiety and panic attacks and possible depression. He has seen Dr. Ballenger for these issues. He also seems to exhibit low pain threshold with high tolerance for narcotics and dependency on pain medication. There was also concern for the possibility of secondary gain in light of the patient's plan to apply for disability related to his Crohn's disease.

The situation has been discussed previously with Dr. Monzel. The patient has been started empirically on high dose steroids in the hopes of reducing any potential inflammatory bowel disease. Unfortunately, he continues to require high doses of narcotics for relief of his pain, which he describes as 10/10 intensity.

PAST MEDICAL HISTORY:

1. Hepatitis C carrier with benign liver biopsy and intermittent hepatocellular dysfunction presumed secondary to previous alcohol consumption.
2. Adjustment disorder, anxiety, panic and possible depression.
3. Crohn's disease with intermittent flares.
4. Allergic rhinitis.
5. History of Staph aureus airway colonization.
6. Status post partial colectomy with incidental appendectomy in 1989.
7. Status post cholecystectomy in 1992.
8. Hospitalization 8/98 for possible nephrolithiasis and renal colic.

MEDICATIONS: This admission the patient is currently on Solu Medrol 100 mg IV q.12h., Xanax 0.5 mg p.o. q.8h., Demerol 100 mg IM q.3h., Phenergan 12.5 mg IV q.4h.

(SEE NEXT SHEET)

ALLERGIES: No known drug allergies.

TOBACCO: Previous one pack per day, although not recently. **ALCOHOL:** The patient has been abstinent for the last year with a prior history of a six pack of beer on a weekend. **OTHER DRUGS:** The patient does not drink coffee or tea. He states he avoids street drugs. **DIET:** Without.

SOCIAL HISTORY: The patient lives with his wife and two children in an apartment. He was working at Falcon Shoe as an injection molder. He stands all day long and describes high stress. He does not do conditioning exercises.

REVIEW OF SYSTEMS: The patient has had persistent abdominal pain which he describes as a 10/10 intensity not responsive to pain medication.

PHYSICAL EXAMINATION: The patient is presently alert and responsive sitting in the hospital bed. He does not appear to be in acute distress, although he complains of severe, incapacitating pain. **VITAL SIGNS:** Temperature 37, pulse 60, respirations 18, blood pressure 100/60. **HEENT:** Normocephalic. Pupils are equal, round, reactive to light. Sclerae are clear. The tympanic membranes and oropharynx and unremarkable. **NECK:** Supple without adenopathy or thyromegaly. **CHEST:** The lungs are clear. **HEART:** Sounds are physiologic. **ABDOMEN:** Soft. Bowel sounds are active. No visceromegaly. The patient complains of severe pain with minimal palpation of the epigastrium and right upper quadrant without rebound. **RECTAL:** Deferred. **GENITALIA:** Deferred. **EXTREMITIES:** Without clubbing, cyanosis or edema. Pedal pulses are intact. **NEUROLOGICAL:** Oriented x 3. Cranial nerves II through XII are grossly intact. Motor and sensory within normal limits. The deep tendon reflexes are intact and symmetric. Gait is not tested. The patient exhibits a flat affect. **SKIN:** Clear.

LABORATORY DATA: This admission white cell count 11,000, hemoglobin 13, hematocrit 37, MCV 93, platelets 285,000. Urinalysis with pH of 7.0, specific gravity 1.007, 250 mg/dl glucose, negative microscopic today. Electrolytes normal with BUN 9, creatinine 0.7 and glucose 139.

IMPRESSION: A 36-year-old male admitted to gastrointestinal service in light of incapacitating abdominal pain and concern for Crohn's flare with early partial small bowel obstruction. However, I perceive that there is a marked dichotomy between the patient's subjective reporting of his pain complaint and his actual clinical and diagnostic findings. He also exhibits marked narcotic tolerance with dependency. I also wonder about secondary gain in light of the fact he plans to apply for disability secondary to his Crohn's disease. I have asked Dr. Ballenger to reassess from a psychiatric perspective. I have also asked Dr. Snyder to assess from a pain management standpoint. His gastrointestinal workup is in progress with an empiric steroid trial per Dr. Monzel.

(SEE NEXT SHEET)

REPORT OF CONSULTATION MICHAELBOULANGER,M.D. MS-301 8278533
FANTOZZI, RONALD M
Page 3

To summarize patient problem list:

1. Severe, incapacitating subjective pain perception which seems out of proportion to clinical findings and diagnostic studies.
2. Marked narcotic tolerance and dependency.
3. Crohn's disease with partial colectomy and appendectomy in 1989.
4. Hepatitis C carrier.
5. Nephrolithiasis and renal colic 8/98.
6. Adjustment disorder, anxiety, panic attacks and possible depression.
7. Possible secondary gain in light of the patient's plan to apply for disability from Crohn's disease.

PLAN:

1. Psychiatry re-evaluation by Dr. Ballenger.
2. Pain consultation with Dr. Snyder.
3. GI workup in progress, empiric steroid trial as outlined by Dr. Monzel.

Thank you for involving me in this challenging patient's care. I will be happy to follow his in-hospital course with you.

MICHAEL BOULANGER, M.D.

D: 10/06/98 MB
T: 10/07/98 emw

cc MICHAEL BOULANGER, M.D. (F)
MICHAEL MONZEL, M.D. (F)
DI/ON (F)

ST. MARY'S REGIONAL MEDICAL CENTER

Lewiston, ME 04240

8278533 MS-300 22-13-42

FANTOZZI, RONALD M
DOB: [redacted]/62
MICHAEL MONZEL, M.D.

REPORT OF CONSULTATION

Admitted: 10/05/98

CONSULTING PHYSICIAN: LUKE BALLENGER III, M.D.
Date of Consult: 10/07/98

REASON FOR CONSULTATION: The patient is a 36-year-old married, white man who is admitted for severe abdominal pain. The chart was reviewed and consult was called to assess his psychiatric condition.

HISTORY OF PRESENT ILLNESS: Mr. Fantozzi has a long history of medical problems including Crohn's disease and is a hepatitis C carry. He had been admitted for progressive severe right upper quadrant and vomiting. He also had a recent history of renal colic and nephrolithiasis. He is on Luvox, he was placed on that by Dr. Michael Boulanger for depression and anxiety. He denies any current suicidal ideation. He is less interested in living. He denies any history of suicide attempts. He does have initial insomnia. He was sleeping six hours at home, but only four hours in the hospital. He has decreased energy, decreased concentration, anhedonia, poor appetite. There was a five pound weight loss in one week. He denies any decrease in self-esteem. He does have helplessness, but not hopelessness. He denies any hallucinations. He has occasional paranoid ideation that people are following him. He denies any thought broadcasting. He does have some ideas of reference that people are talking about him. He has crying spells. He denies any history of grandiosity, mood swings or excess energy. He does have anxiety attacks with numbness in his arms, dizziness, contractures of the fingers, nausea, shortness of breath and tachycardia. This lasts a half a day and they are spontaneously. They occur about four times a month and minor symptoms occur more frequently than that. He has agoraphobia related to the anxiety attacks. He also admits to be noncompliant about twice a week with his Luvox. He has alcohol usage of about a six pack per week. His last drink was about five months ago. Once in a while he drinks a six pack per night. He denies any OUI arrests, but does have a history of black outs, but no withdrawal tremors. He told Dr. Monzel that he has about 1-2 beers two to three times per week. He denied tobacco usage to Dr. Monzel. He denies any drug abuse, and he denies abusing prescription drugs even though he has been to the emergency room recently for complaints of abdominal pain and was receiving some opiates at those times.

PSYCHIATRIC HISTORY: He was seen by me for three visits in the early fall of 1995, but subsequently did not continue to follow up with me, and now follows up with Dr. Michael Boulanger for his psychiatric medicines. He is currently on Luvox 50 milligrams p.o. q. h.s. I had tried him on Desipramine but he states that he has impotence with that. I have also

(SEE NEXT SHEET)

tried him on Serzone which his complaints back three years ago were that the Sersone gave him increasing anxiety. He reported at that time that Vistaril was beneficial but worked slowly in regards to his anxiety. At that time, he had been tried on Zoloft for two days but quit it due to neck pain, that was in the early part of 1995. He has also been on Xanax in the past.

MEDICAL HISTORY: He has a history of recurrent bronchitis and Crohn's disease. He also has a history of being a hepatitis C carrier. He denies hypertension, or diabetes mellitus.

ALLERGIES: None known.

SURGICAL HISTORY: Partial colectomy, as well as, cholecystectomy and appendectomy, as well as, recent stent placed for his renal colic.

FAMILY HISTORY: Significant for alcohol abuse in the father, mother, brother and cousins. There is no family history of drug abuse. There is a history of psychiatric problems in the mother. Previously in 1995, the patient stated that there was no alcohol abuse in his family. At that time in 1995, he denied any psychiatric problems in his family. There is no family history of suicides. There is a history of Alzheimer's disease in the mother, history of congestive heart failure in the mother.

SOCIAL HISTORY: He was born in New Brittain, CT, he is the third of three children. He has a history of physical abuse. He completed eighth grade at the age of 16 and went to work, he repeated first and third grade, he is a slow learner, and he was in special education for reading and writing. He was married once, and he was married in 1986. He as three children, one child is by another woman who he sees on occasion. He denies any legal problems. He is working at Falcoln Shoe. He is currently on disability leave and has been for the last six weeks.

REVIEW OF SYSTEMS: RESPIRATORY: He has complaints of shortness of breath. **CARDIOVASCULAR:** He has complaints of irregular heart beats. **GASTROINTESTINAL:** Severe abdominal pain. **GENITOURINARY:** Complaints of impotence. **NEUROLOGICAL:** Complains of weakness. **BACK:** Complains of pain. **EYES:** He has what seems to be described as a detached retina with some bleeds in the back of his eye. **EARS:** Decreased hearing. **SKIN:** No complaints. **NOSE:** No complaints. He has dry nares.

MENTAL STATUS EXAM: He is alert and oriented to person, November 10, 1998, Tuesday, at St. Mary's. His mood is "not too good". His affect was dysphoric. Speech was normal rate and tone. Behavior, he appeared to be in pain and was laying in bed and quickly turned and repositioned himself in bed. Thought processes were concrete, but goal directed. Thought content, he denied suicidal ideation. He had anhedonia, insomnia and

(SEE NEXT SHEET)

decreased appetite, decreased concentration and decreased energy, helplessness, occasional paranoid ideation and he has crying spells. He also had anxiety attacks with agoraphobia.

On cognitive exam immediate recall three out of three objects at one minute, one object out of three at five minutes. Proverbs he was able to abstract to, "don't cry over spilled milk". Serial threes he did with one mistake.

IMPRESSION: This is a 36-year-old man with history of multiple medical problems and difficulty in controlling pain. He also has signs and symptoms of a panic disorder, as well as major depression.

DIAGNOSES:

Axis I: Major depression, recurrent, moderate symptoms, panic disorder with agoraphobia.
Axis II: Deferred.
Axis III: Crohn's disease, history of hepatitis C carrier state, history of allergic rhinitis and history of renal colic.

RECOMMENDATIONS:

1. Restart the Luvox 50 milligrams p.o. q. h.s. for one day an then increase to 50 milligrams b.i.d. to help with his depression and his anxiety.
2. Change his Xanax to Ativan 0.5 milligrams p.o. b.i.d. and q. h.s. This is somewhat longer acting than Xanax, and should help with some of the anxiety between doses of his opiates.
3. Try to minimize opiates to control the pain, and further recommendations per the chronic pain consult.

LUKE BALLENGER III, M.D.

D: 10/07/98 LB
T: 10/08/98 alh

cc: LUKE BALLENGER III, M.D. (P)
MICHAEL BOULANGER, M.D. (P)
D3/ON (P)

ST. MARY'S REGIONAL MEDICAL CENTER

Lewiston, ME 04240

8278533 MS-300 72-13-42

FANTOZZI, RONALD M
DOB: [redacted]62
MICHAEL MONZEL, M.D.

REPORT OF CONSULTATION

Admitted: 10/05/98

CONSULTING PHYSICIAN: RONALD SNYDER, M.D. Date of Consult: 10/08/98

Mr. Fantozzi is a 36-year-old gentleman who has significant medical problems including an approximately ten year history of Crohn's disease, ultimately seven years ago undergoing ileal right colonic resection, that has remained fairly quiet until the last several months until he began having progressive pain and intermittent diarrhea.

He indicates that initially he was told that they thought he had a renal stone. He progressively has had increasing pain such that he was admitted on the service of Dr. Michael Monzel on October 5, 1998, for progressive pain with repetitive vomiting.

STUDIES: He indicates that he has had x-rays in August, September and October of 1998. Colonoscopy in September of 1998, CT scan August of 1998, multiple blood studies, and has had full urinary evaluations in August of 1998.

PAIN DIAGRAM: He notes pain in the substernal region, pain in the right upper quadrant, pain in the right lower back flank region, along with numbness and tingling down the anterior and posterior portions of both arms, as well as, a band like area going across the abdomen on both sides over the right flank and side region, but not over the left posterior region.

TREATMENTS AND THEIR EFFICACY: He indicates that Demerol resolves in 80% reduction in pain, Percocet 60-70% reduction in pain, and 40% reduction with Tylenol.

PAIN INTENSITY: He indicates pain at its worst as ten out of ten, and at least four out of ten with zero being no pain and ten being worst imaginable pain.

VARIABILITY IN PAIN: He notes driving, dressing, fatigue, going to work, sexual intercourse, household chores, liquor, loud noises, mild exercise, movement, pressure, standing, sitting, socialization, stimulants, stretching, tension, thinking of work, touching, bowel movements and walking all seem to make the pain worse. He has noted specifically, that heat, lying down, massage, medication, no movement, relaxation, sleep seem to improve his level of pain.

(SEE NEXT SHEET)

PAIN DESCRIPTION: He describes pain as flickering, throbbing, beating, shooting, stabbing, sharp, cutting, cramping, retched, dull sore, hurting, aching, tender, rasping and splitting (17 out of 41 somatic pain descriptors).

He also describes his pain as tiring, exhausting, sickening, suffocating, fearful, frightening, terrifying. (Consistent with 50% of affective pain descriptors on the McGill-[redacted] questionnaire). McGill-Melzack

He notes an overall feeling of helplessness and hopelessness (depression), as well as, a marked amount of restlessness, irritability, panic and rage, excessive adrenaline. He further has noted that the pain has resulted in decreased memory, attention and concentration consistent with perhaps overload of the limbic system of the brain.

PERCEIVED LEVEL OF DISABILITY: He indicates that the pain has resulted in 100% change in socialization and occupational potential, 80% change in family and home responsibility, recreation, sexual behavior, life support, and 20% changes actually occurring around self-care.

GENERAL HEALTH REVIEW: He indicates that he has a positive history for kidney stones, status post gallbladder removal, hepatitis C, arthritis, anxiety, Crohn's disease and a history of hyperchondria.

SURGICAL HISTORY: He indicates that he has had one and a half feet of his intestines removed along with his appendix. He indicates that his gallbladder has been removed. He indicates that he had "bone surgery" for broken wrist and fingers, and indicates that he has had "surgery to break up kidney stones".

ALLERGIES: "Bad hay fever".

INTOLERANCES: "Zoloft kept me awake all night".

DIET: He does not eat three regular meals a day. He indicates that on average on a daily basis he consumes red meat, white meat, sugar, vegetables, pasta, fruits, breads, eggs, colas and cereal. He indicates that he eats on average more than four snacks per day utilizing small bites and will essentially eat anything.

SLEEP: He indicates that he always has trouble falling asleep and always needs to take medications for sleep. He indicates that sometimes he awakens by pain. He sleeps on an average of four to five hours per night.

DOMESTIC SITUATION: He resides at home with his wife and two children. He does have a teenage daughter who he sees on the weekends who resides with his previous wife. He indicates that his wife works for Tambrands on the production line. He indicates that

(SEE NEXT SHEET)

his wife is supportive in the fact that she listens and is very caring and understanding, and attempts to do things like call the doctor, and get him things if it is needed.

When asked whether he was capable of caring for himself, he indicates yes, although when he does have a bad anxiety attack and hyperventilates his wife calms him down and helps him concentrate on breathing through a paper bag.

BECK INVENTORY DEPRESSION SCALE: He indicates that he is so sad and unhappy that he can not stand it. He is discouraged about his future, and feels guilty a good part of the time. He feels that he is being punished, and at times gets annoyed or irritated more easily than in the past. He notes that he has lost interest in all people, and notes that he has greater difficulty in making decisions than before. He feels he can not work at all, and that he awakens several hours earlier than usual and can not sleep, and is essentially too tired to do anything. He notes that he is critical of himself and for his weaknesses, and notes that he cries more than he used to. He scores a total of 28 consistent with severe depression.

EDUCATIONAL BACKGROUND: He did not complete high school, having gone to work early. He did not obtain his GED and has not served in the service.

WORK HISTORY: He worked for Martel Meats for two years due to the fact that he missed a lot of work he got fired. He worked for Falcon Shoe for ten years, and left because he was disabled. He worked for Supreme Slipper for four to five years and was laid off. He worked for Quoddy Moccasin for two to three years and the place closed down. He indicates that he was not on light duty at the last time he worked. He notes that he would stand most of the day pushing and pulling moldings, and that he was working around polyurethane and other chemicals, and due to the fact that he missed a lot of work for his illness this resulted in stress and sleeplessness while attempting to work. He noted that he had a good relationship with his co-workers and that his employer has been patient, and that they have actually contacted his wife to see how things are going.

LEGAL MATTERS: Although he indicates he has no legal situations, and no attorney, he indicates that he would like to have help in obtaining disability.

SUBSTANCE ABUSE: Occasionally uses alcohol.

MAST QUESTIONNAIRE FOR ALCOHOLISM: He scores zero with no indication of alcoholism. He did smoke approximately two to five cigarettes per day for five years or so, but does not smoke.

Today we spent over an hour reviewing this gentleman's history and discussing his pain management.

(SEE NEXT SHEET)

REPORT OF CONSULTATION RONALD SNYDER, M.D. MS-300 8278533
FANTOZZI, RONALD M
Page 4

He notes a high level of anxiety when he has pain, and notes that when he has high levels of anxiety his pain worsens. He notes marked sleeplessness, and today we spent a great deal of time of how sleeplessness, anxiety, all play havoc with particularly gastrointestinal pain.

I have read the chart and particularly totally agree with psychiatry's evaluation.

SUGGESTIONS:

1. If indeed pain worsens we would suggest utilizing very little in the way of central acting drugs and perhaps if needed, we would only utilize perhaps low doses of Methadone.

I do believe that this patient has more psychiatric problems that are significantly flared now that he has an actual medical condition including c.difficile infection on top of Crohn's disease.

I do believe however, that the psychiatric problems are magnifying much of his pain, and I am fearful that if we overtly treat him we will end up having a permanently disabled patient who will have a major disabling perspective on his future.

I did suggest to him that it might be appropriate to refer to him to Willy White who is a pain psychologist at Medical Rehabilitation Associates (783-2300). Willy exclusively works with patient's who have pain and has a very good rapport with such patient's as I see in Ron. Six to eight sessions of dealing with adjustments of disability, anxiety management and particularly the use of multi-channel EMG bio-feedback may be helpful.

Thank you very much for allowing me to see this patient in consultation.

RONALD SNYDER, M.D.

D: 10/08/98 RS
T: 10/09/98 alh

cc RONALD SNYDER, M.D. (F)
D3/ON (F)

S HR 21342
MENZEL, MICHAEL J
RONALD M
4 POLAND RD
ME 04210
[redacted]/62 M/M 207-7823873
218103-01 999999

ADMITTING PROGRESS NOTE

Date

Admission Notes:

10/5/98 GL — 36 y/o ♂ admitted with hx (R) sided abdominal pain. Long standing hx of Crohn's disease → s/p ileo + (R) colon resection 7 years ago. Crohn's quiescent for several yrs but now with several mos of progressive pain → Admission 5/98 c̄ presumed cholecystitis. Pain has continued as has low grade diarrhea. Recent UGI/SBFT has suggested an ileal narrowing — no proximal small bowel distention. Colonoscopy revealed [illegible] anastomotic [illegible] c̄ an ulcer. CT ⊖. He [illegible] He has had progressive pain x 1 week — [illegible] post prandial [illegible] + pain

O on exam — NAD
Abdom ⊕ R LQ tender — mild distention BS ↓
KUB — small bowel dilated [illegible]
TI c̄ an ulcer —
WBC 11,300 [illegible]

Admitting Diagnosis: Partial SBO complicating Crohn's dz

Plan of Management: Bowel rest / analgesia
IV steroids

REFERRAL TO SOCIAL WORKER—DISCHARGE PLANNING (Please Check) ☐

Surgery Anticipated: ☐ YES ☐ NO DATE:

Surgical Procedure:

History & Physical Dictated: ☒ YES ☐ NO DATE: TIME: RECORDER #:

[signature]

F10109 Attending Physician Signature

CONTINUE PROGRESS NOTES ON REVERSE SIDE

500685.011.0137

Fantozzi Ronald 827 8593

221342

DATE	(CONDITION OF WOUND, DRAINAGE, REMOVAL OF STITCHES, COMPLICATIONS, RESPONSE TO TREATMENT ETC., CONDITION ON DISCHARGE, INSTRUCTIONS TO PATIENT, SIGNED RECORDING PHYSICIAN EACH TIME.)
	ROLAND RD AUBURN ME 04210 [redacted] 62 M/M 207-7823873 218103-01 999999
10/6/98 GI · MS4	S: Pt had one episode diarrhea this a.m., still passing flatus. Experiencing some mild abdominal bloating after taking po. liquid. Some mild nausea, no vomiting. Pain relieved c̄ demerol.
	O: VS: 36.5 74 (↑100 on exam) 110 120/80 I: 2720 + sips O: 2475 + ht.
	Exam: Alert & oriented, somewhat anxious.
	Lungs CTA bil CV: tachy, RRR, no m/r/c
	Abd: hyperactive BS, soft, mildly distended, RLQ tender to palpation + referral from LLQ, no rebound, some guarding
	A: Partial SBO 2° to exacerbation of Crohn's disease
	P: Keep NPO - sips for comfort. Continue - i.v. steroids, analgesic
	- Consider imuran if inadequate response to steroids
	Dr. [signature] MS4
	[signature]
10/6/98	As above - still well per will smell for demerol to NPO
	Abdomen remain hyper well on Rt sided tender
	WBC 12,500
	P - continue IV steroid
	MSO4
	clear liquids
	Xam
	[signature]

PROGRESS NOTES

500685.011.0138

8278533

Fantozzi, Ronald

DATE	(CONDITION OF WOUND, DRAINAGE, REMOVAL OF STITCHES, COMPLICATIONS, RESPONSE TO TREATMENT ETC., CONDITION ON DISCHARGE, INSTRUCTIONS TO PATIENT, SIGNED RECORDING PHYSICIAN EACH TIME.)

10/6/98 MS-4 GE Admit/Consult

Impression: 37 y.o. ♂, hx Crohn's, c/o 2 months ↑ing, RLQ pain, diarrhea, x-ray c/w PSBO.

1) Crohn's disease, c partial SBO
   a) s/p ileocolectomy (partial), appendectomy 1989
2) Hepatitis C
3) s/p Cholecystectomy 1992
4) Adjustment disorder c anxiety and panic features
5) Hx renal colic, nephrolithiasis

Plan: # Crohn's/PSBO: - keep NPO, follow I/O, wt.
- iv. Solumedrol, demerol
- i.v. hydration
- consider parenteral nutrition if pt unable to take p.o. after 2-3 days steroids
- consider trial of Imuran if inadequate response to steroids
- Follow CBC, E-lytes

* Hx HepC: possibility of exacerbation c steroids
- Follow LFTs

* Hx anxiety, panic: some sx related to most recent Crohn's exacerbation. May consider pcn Xanax if appropriate

CC: RLQ Pain, c diarrhea

HPI: 36 y.o. ♂, hx Crohn's disease, s/p partial ileocolectomy, also hx HepC, c/o ~2 months worsening RLQ pain, ↑ing diarrhea to 8-10 episodes/day - described as liquid brown stools no blood, some mucous

D. [illegible] MD

FKM06 PROGRESS NOTES

Admit/Consult

→ Pt has been vomiting last 2 days, increasingly severe. Was last hospitalized mid August ē renal colic + suspicion of passed stone. Pt reports he had RLQ pain at that time that never really resolved. He was started on Pentasa 500 qid, and was begun for worsening Crohn's (had been relatively quiescent since 1993-present). Wkup has included:

- CT 9/11/98: read as normal
- Colonoscopy 9/14/98: - focal ulceration + hyperemia ē mild narrowing @ anastomosis, c/w recurring Crohn's
  - nl colon + proximal ileum
- Small bowel series 10/4/98 - focal narrowing of sm. bowel lumen in RLQ c/w Crohn's
- KUB 10/4/98 - air filled sm. bowel - minimal distention

During the past 2 wks, pain has increased to the point that only minimal control was achieved ē p.o. Percocet - was unable to sleep night before admission due to pain; unable to take p.o. since day before admission.

PMH: As outlined previously

Meds: Pentasa 500 mg qid

Percocet prn - usually q 6° last 2 months

Luvox

Allergies: NKDA

Family Hx: Maternal aunt ō colon CA; mother and aunts - gallstones →

PROGRESS NOTES

500685.011.0140

PROGRESS NOTES

8278533

Fantazzi, Ronald

- otherwise non contributory

Soc Hx: remote tobacco hx, ETOH - 5 1/2 pack/week until last 2 months - hasn't felt well enough to drink Caffeine - about 1 liter pepsi/day, milk - race

R.O.S: ⊕ Malaise x 1 wk, Frontal headache x 4 days, nausea/vomiting x 2 days, anorexia x 1d, occasional diarrhea x several weeks, as above.

⊖ Wt As, fevers/chills, syncope, DOE, PND, melena/hematochezia coffee grounds emesis, dysuria/incontinence - otherwise ⊖

Exam: VS:

Head: normocephalic, atraumatic

Eyes: PERRLA

Nose/Throat: no exudate. Mild irritation posterior oropharynx

Neck: supple, no JVD, no lymphadenopathy

Lungs: CTA bil

Cor: RRR, no m/g/r

Abd: nl BS, soft, non-distended, RLQ tender, also L>RLQ referred tenderness, no rebound, no masses

Ext: distal pulses palpable, equal. No edema

Neuro: CN II-XII grossly intact. Motor 5/5 bil UE & LE. Patellar, Bicipital reflexes 1+ bil.

500685.011.0141

PROGRESS NOTES

FI0106

10/4/95 Admit/Consult, cont'd

→ Labs: (10/5) | 10/4

13.3 / 11.3 X 285 / 37.8 ; 139 / 104 / 3.6 / 28	Gluc 92 — T.Bili 1.5
SE 93.6mm	BUN [illegible] — D.Bili 0.5
MCV = 93.5	Creat 0.7 — SGOT 75
UA: [illegible] Glucose 250	T.Prot 8.5 — SGPT 104
Ø Ketones	Alb 4.0 — AlkP 91
otherwise ⊖	Ca++ 10

Acute Abdomen series: Chest - nl
KUB - air-filled, mildly distended small bowel ↑'d somewhat compared to 10/5, no air-fluid levels

D. Stuthld MS-4

DATE

(CONDITION OF WOUND, DRAINAGE, REMOVAL OF STITCHES, COMPLICATIONS, RESPONSE TO TREATMENT ETC., CONDITION ON DISCHARGE, INSTRUCTIONS TO PATIENT, SIGNED RECORDING PHYSICIAN EACH TIME.)

[illegible]
508503

221342
MICHAEL J
RONALD M
RD

DATE	(CONDITION OF WOUND, DRAINAGE, REMOVAL OF STITCHES, COMPLICATIONS, RESPONSE TO TREATMENT ETC., CONDITION ON DISCHARGE, INSTRUCTIONS TO PATIENT, SIGNED RECORDING PHYSICIAN EACH TIME.) 3873
6 OCT 98	MEDICINE ATTENDING 7:30PM
	• SHOWN TO CONSULTED MEDICAL HX ADMITTED FOR SEVERE ABD. PAIN PRESUMED 2° CROHN'S FLARE TO ? EARLY PARTIAL SBO.
	• PT. WELL KNOWN TO ME. CHART REVIEWED AND CASE PREVIOUSLY DISCUSSED W DR. MONZEL.
	[MP] #1) SEVERE INCAPACITATING SUBJECTIVE PAIN PERCEPTION WHICH SEEMS OUT OF PROPORTION TO CLINICAL FINDINGS + DIAGNOSTIC STUDIES
	#2) MARKED NARCOTIC TOLERANCE W DEPENDENCY
	#3) CROHN'S DISEASE W PARTIAL COLECTOMY/APPENDECTOMY
	#4) HEPATITIS C CARRIER
	#5) NEPHROLITHIASIS W RENAL COLIC 0/98
	#6) ADJUSTMENT DISORDER W ANXIETY, PANIC ATTACKS AND POSSIBLE DEPRESSION
	#7) ? SECONDARY GAIN IN LIGHT OF PT'S PLAN TO APPLY FOR DISABILITY 2° CROHN'S
	PLAN 1) PSYCHIATRY REEVALUATION DR. FALLENGER
	2) PAIN CONSULT DR. SNYDER
	3) GI W/U IN PROGRESS W EMPIRIC STEROID TRIAL PER DR. MONZEL
	Thuly M. Bowlyn

F10106 PROGRESS NOTES

PROGRESS NOTES

MS MR 221342
MICHAEL J
RONALD M
ROLAND RD
ME 04210
[redacted] 207-7823873
21-103-01 999999

3/7/98 # Crohn's colitis / [illegible]
OI # Perianal SBO

S - better night but pain still "severe" + alleviating episodes

O - afebrile
Abdomen absolutely soft [illegible] sounds
stool (+) C. diff
significant diarrhea [illegible]

A - C. diff complicating Crohn's
steroids do not suppress as [illegible]
documented Crohn's [illegible]
- pain clearly out of proportion to objective findings now

P - advance diet
- po vancomycin
- continue IV steroids until 24 hrs
- ✓ LFT's
- pain consult

[signature]

221342
PENZEL, MICHAEL J
BARTOZZI, RONALD M

(CONDITION OF WOUND, DRAINAGE, REMOVAL OF STITCHES, COMPLICATIONS, RESPONSE TO TREATMENT ETC., CONDITION ON DISCHARGE, INSTRUCTIONS TO PATIENT, SIGNED BY RECORDING PHYSICIAN EACH TIME.)

823873
999999

DATE	
7/7/98 MS-4 GI	# Crohn's ileitis
	# Partial SBO
	# C. Difficile infection
	S: Pt is in pain, better controlled c Demerol than MSO4. Still having multiple episodes of diarrhea. Less nauseous, able to take p.o. clears
	O: VS 36° 80 16 130/70 Wt 104.9 ↓ 0.5 kg (yesterday)
	I/O: 2880 / 2775 + BM ×6
	Exam: Alert + oriented, NAD
	Abd: hyperactive BS, soft, non-distended, RLQ tender as before, no masses
	Stool ⊕ for C. Diff
	A: -Crohn's disease - active, h/o hypC
	-C. Diff colitis
	P: Crohn's Continue steroids
	↓ IVF c ↑ p.o. intake
	advance diet slowly
	C. Diff: p.o. Vancomycin
	hypC: ✓ LFTs
	pain: Pt c inordinate subjective pain, narcotic tolerance → pain consult
	[signature] MSIV
7 Oct 98	MEDICINE
	• PAIN INTENSITY SAME.
	• TAKING PO.
	• EXAM UNCHANGED.
	PLAN 1) AWAIT OPINIONS DR. SNYDER + DR. [illegible]
	2) C. DIFF. TX PER DR. MANZEL

F10106 PROGRESS NOTES

PROGRESS NOTES

221342
HONZEL, MICHAEL J
FRITTUZZI, RONALD M
RE 04210
[redacted] 62 W/H 207-7823873
213185 31 999999

10/07/98 Psych Consult
36 y/o white man adm
for abd pain. chart reviewed consult
called to assess & cond.
HPI – Pt c long hx Crohn's, mult med
problems, followed by Dr Monzel
He is on Luvox 50 mg qHS. Denies suicidal
idea ⊕ less interest in living. No suicide
attempts ⊕ initial middle terminal
insomnia, ↓ energy ↓ concentration,
anhedonia, poor appetite ⊕ helpless,
⊕ occasional "paranoid idea people follow
him ⊕ idea of reference people talk about
him. ⊖ crying ⊕ agoraphobia
Anxiety c numbness, dizzy, tachy
cardia, 1-2 day spontaneous
4x/mo. noncompliant c Luvox
⊘ drug abuse ⊕ ETOH 6 pack
last drink 5 mo ago
Ψ – 1995 3 visits only c me
noncompliant c Follow ups
Med – see chart
Fam Hx – ⊕ ETOH – parents, bro, cousins
drugs ⊕ "nervous" ⊕ Alzheimer's
No suicide hallucinations

221342
MICHAEL J
RONALD M
POLAND RD
823873
218103-01 999999

DATE	(CONDITION OF WOUND, DRAINAGE; REMOVAL OF STITCHES, COMPLICATIONS, RESPONSE TO TREATMENT ETC., CONDITION ON DISCHARGE, INSTRUCTIONS TO PATIENT, SIGNED RECORDING PHYSICIAN EACH TIME.)
10/07/98	(Cont) Socially - Born in Ct. slow learner
	Hx of physical abuse 8th grade educa-
	tion Special Ed
	MSE - Alert DX Prison 11/10/98 St Mary's
	Mood "not too good"
	Thought Process concrete
	3/3 at 0', 1/3 at 5'
	Proverb abstract Serial 3s - one
	mistake
	IMP I Major Depress. Recur
	Panic Disorder c Agoraphobia
	II def
	III Chronic Bronchitis
	Hep C Carrier, arthritis
	Rec (1) Luvox 50 mg hs x 7 d then
	↑ to 50 mg BID
	(2) Δ Xanax to Ativan - longer
	acting
	(3) minimize opiate use to
	control pain -
	Luke Ballinger — dictated
	Tutty MS

F10106 PROGRESS NOTES

PROGRESS NOTES

E276533 MS MR 221342
1799 MONZEL, MICHAEL J
PANTOZZI, RONALD M
~~4 POLAND RD~~
AUBURN ME 04210
[redacted] ~~VL2 W/M 207-7823075~~
218103-01 999999

GI - MS4 P.N.

10/8/98 S: Eating solids now, pain improved but still present, especially p eating, some mild bloating c eating.

O: 36.4 68 16 128/68 Wt:

I/O: 4480 / 2975 + BM x 7

Exam: Lungs CTA Cor RRR s m/g/r

Abd: active BS, soft, mildly distended, tender RLQ, no mass

Labs CBC, lytes panel ø

A: 36 y.o. ♂ c Crohn's dz, complicated by C. Difficile infection.

HS neg C, ψ issues: depression, anxiety; improving

P: - Δ to p.o. steroids

- cont to advance diet as tolerated

- Pain consult ordered - ... to minimize narcotic use

- Continue Vancomycin

Dan Stuttle MS-4

[illegible signature]

C,T As above

States pain is slightly improved

2 10 BM's yesterday - 2 today → ...

without stool formation, 56 ... 77 / ... 87 → stable

Will switch to oral steroid

continue lavage

& frequency of stool

[illegible signature]

P278533 MS MR 221342
MENZEL, MICHAEL J
ME 04210
AUBURN [redacted] 762 207-7823873
CITY 999999
212103-01

DATE	(CONDITION OF WOUND, DRAINAGE, REMOVAL OF STITCHES, COMPLICATIONS, RESPONSE TO TREATMENT ETC., CONDITION ON DISCHARGE, INSTRUCTIONS TO PATIENT, SIGNED, RECORDING PHYSICIAN EACH TIME.)
10/8/98	Physiatry:
	• See dictated note • withdrawn from social interaction
	• Severe depression ⟷ • Poor sleep
	• Severe anxiety
	Chronic ↔ Cdiser
	• Desire for disability
	• Some caffeine intake
	• Marked diffuse pain (Symptom magnification)
	Suggestion ① Avoid central narcotic if needed? long methadone
	② Referral to Willy White / med Rehab - 783-2300 for out patient
	bio behavior for stress management, bio feed back
	positioned to disability
	③ Agree with Psychiatry
	[signature] MD
9 Oct 98	Medicine
	• Consultants' insights appreciated.
	• Await response to psychotropic meds.
	• Outpatient behavioral counseling / stress management
	[signature] MD

F10106 **PROGRESS NOTES**

2213

MR MS MONZEL, MICHAEL J
FANTOZZI, RONALD M
POLAND RD ME 04210
207-7823873
A-BURN[redacted]162 M/N 999999
03-01

PROGRESS NOTES

G.I. MS4- PN

S: Pain improved, sleeping better, eating solids c̄ caution.
2 BMs yesterday - semi formed. Still requesting pain meds. Says "I'm definitely feeling better"

O: VS 36.2 76 20 122/64 Wt 65.1 Kg ↓0.3 Kg

PE Lung Clear CV RRR s̄ m
Abd: BS less hyperactive, soft, nondistended, tender in RLQ but able to tolerate deep palpation

Labs (10/8) 12.9 / 14.3 / 245 / 37.5 Chem panel
34 c 53.5 Band
Albumin 3.6
T.Bili 0.7 SGOT 37
AlkP 65 SGPT 77

A: * Crohn's - improved
* C.Diff infection
* h/o Hep C
* Pain/anxiety issues

P: * Crohn's - much improved from this standpoint - will continue on p.o. steroids and taper as indicated
* C.Diff - con Vancomycin
* h/o Hep C - high dose steroid use - no apparent adverse effects - Liver panel nl
* Pain/anxiety: Psychiatry input noted. will d/w Dr. Boulanger methadone vs current pain meds

Dan Stutler MS4